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The emergence of the Consultant Venereologist

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It may be questioned whether there is more venereal disease in the United Kingdom today than there was at the turn of the century. Though we may have no statistics relating to that time, this much may be said—there was plenty about and, whatever attitude may have been adopted to sexual indiscretion, in whatever contempt sufferers from venereal disease may have been held by the public, no stigma was attached to those who treated syphilis and gonorrhoea. Indeed, the subject was associated with the names of great men on both sides of the Channel. And the medical profession had good reason to appreciate the prevalence of venereal infections. The latter half of the last century was a golden age for clinical medicine and much knowledge, both physiological and pathological, was acquired and annotated by astute and diligent observers. Syphilis entered into the differential diagnosis of nearly every disease to which mankind was heir. Successful neurologists owed much of their living to the ubiquity of the pale spirochaete whose very existence was as yet unknown.

Those familiar with the famous statistics of Bruusgaard (1929) will know that Böeck of Oslo was perhaps the first to realize that inadequate treatment was worse than none at all for it left patients uncured but defenceless. Small wonder that today we no longer or seldom see pseudo-chancre redux, precocious tertiarism, late chronic polymorphic syphilides, foetid gummata, lingering incontinent paralytic insanity, and the like.

The momentous discoveries by Schaudinn and Hoffman (1905) of *Treponema pallidum*, by Wassermann (1906) of his serological reaction, and by Ehrlich and Hata (1910) of the organic arsenicals, constituted 'a triumph of constructive thinking that within one decade raised empirical medicine . . . to the dignity of an exact science' (Stokes, Beerman, and Ingraham, 1944). A specific drug for a specific organism in a prescribed dose, according to body weight, was on the market and we were all set for Ehrlich's 'therapia sterilans magna'. It was at this time that society was profoundly concerned with its own involvement in venereal disease; even politicians came to notice things amiss. The Royal Commission of 1913 was set up and the V.D. Act was passed in 1917.

It must have been about then that the profession's contempt for the subject of venereology took root. Now that treatment was on the way to becoming stereotyped and now that patients no longer had actually to pay for their treatment, there was less occasion for private practitioners to run the risk, as they thought, of actually shaking hands with their patients. As deference was no longer due, the profession was able to do a *volte face* and began to treat patients with the contumely they had obviously always been thought to deserve.

Particular clinical expertise in diagnosis and treatment were no longer thought to be a pre-requisite for the management of the multitudes attending the newly set up clinics. Those who chose to man them did so largely for modest remuneration. Running the V.D. clinic was decidedly a second string to the bow of the dermatologist (for skin lesions were legion); of the genito-urinary surgeon (for gonorrhoea was tedious to treat and frequently complicated—armed with sounds, Kollman dilators and astringent antiseptics they inadvertently saw to that); or of the assistant medical officer of health (for the clinics were under the jurisdiction of public health departments).

Many turned up late and went early and left the routine work to that noble, praiseworthy but now rapidly disappearing band of stalwarts, the V.D. technicians on the one hand, and to devoted middle-aged sisters with a sense of vocation on the other. Hospital committees and medical staff alike unwittingly showed their contempt for the V.D. patient by putting him in the basement with second-hand equipment next to boiler houses, kitchens, and other places lacking both aesthetic value and clinical pretension. All this adversely affected the esteem, or lack of it, in which the physicians-in-charge were held. The 'Pox Doctor' was born and, but for a few luminous exceptions in the large centres, quietly went

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about his business in an aura of subdued anonymity, and there he stayed for many a year.

The fact that venereology was the Cinderella of Medicine for so long means that many who came on the scene just before, during, or after the last war can testify to their difficulty, if not in ingratiating themselves with their colleagues, at least in creating some air of respectability for the subject.

Some may possibly recollect a slap on the back from a jocund colleague asking 'How's trade'?—a question the least disrespectful or sentimental of us would hardly put in such terms to say—the cardiologist. Another would regard the venereologist's presence as the signal for recounting an obscene yarn or apocryphal tale, for the 'clap' or the 'pox' called for ribaldry. Those who have but recently arrived on the scene may possibly acquire a vicarious awareness of such tedious attitudes by observing the range of tolerance that exists between their young contemporaries on the one hand and some elderly members of the profession outside venereology on the other.

There was perhaps some slight justification for the denigrating appellation of 'Pox Doctor' during the war, at least in the Services, for there one was very much involved with otherwise healthy young adults suffering from gonorrhoea or early infectious syphilis. Military adjectives of one sort or another were a routine, and a touch of affection might have been discerned in the use of the term 'Pox Doctor', just as all medical officers were known as 'Quacks'. No one then, however, should have been unmindful of the great debt due to the late Col. Harrison. His tireless, ceaseless battle with authority, coupled with his research and teaching starting in World War I and maintained throughout his professional life, resulted at least and at last in the recognition of venereology as a specialty in its own right. This was the inevitable first step towards its ultimate recognition in civilian practice in the National Health Service.

Most venereologists knew their limitations at that time, but as Harrison said, 'If physicians won't become venereologists, it behoves venereologists to become physicians'. They soon learned also that their horizon, medically speaking, was limitless. They set about trying to make their presence felt. Even pointing out the ignorance and shortcomings of others has slowly served to put venereology on the map. Perhaps obstetricians took their bearings with more commendable perspicacity than others and accepted the venereologist's services with greater alacrity. Other consultant colleagues were somewhat dilatory about using these services. Many physicians in the early 1950s were reluctant to subject their patients to the embarrassment, not to say, insult of an appointment with a specialist in venereal diseases. With dogged individualism they would continue to manage their own cardiovascular and neurosyphilis cases (barrier nursing and all). Nor is there any prescriptive reason why they should not. On the other hand, a few would occasionally discuss modern treatment with the venereologist, either with a view to avoiding errors in their own practice or more rarely, to transcribing a long telephone conversation into a chapter on the treatment of—say—neurosyphilis, in an edited textbook of medicine.

To today's younger generation we can say with ample justification 'We have arrived'. However much a few specialists in other branches of medicine and indeed some older practitioners may think in terms of one injection of penicillin for gonorrhoea and twenty for syphilis, or even twenty for gonorrhoea and one for syphilis, and however much we older venereologists had to fall back on the spectre of non-gonococcal urethritis to justify our continued existence, society as a whole has been obliged to take note of the fact that venereal disease is not so much a medical problem as an epidemiological one. We have known this all along and have had no need to justify our very existence to ourselves, but the profession as a whole has only recently awakened to our role in society.

The V.D. Department, originally a clinical cess-pit, has become an integral part of a diagnostic and therapeutic set up. 'Our man in the clinic', from being a refuge for medical and social pariahs, to providing an 'on demand' service for patients and doctors alike, in short from being 'Pox Doctor' to becoming Consultant Venereologist, has undergone a gradual metamorphosis which has lasted for a quarter of a century. Today his hospital colleagues refer their cases and respect his opinion. Some recent figures provide evidence for the use being made of the venereologist as a consultant colleague. During the years 1969, 1970, and 1971, 77 different consultants covering sixteen different specialties referred 179 patients to the department of venereology at the Newcastle General Hospital (Table I).

Of the patients, 150 were ambulant and seen in the department, while 29 were bed patients and seen on the wards. Of much significance to the changing pattern of venereology in the United Kingdom are the figures for two cardiologists who found only three fresh cases of cardiovascular syphilis in 3 years; for two paediatricians who referred only seven patients, including five cases of ophthalmia neonatorum but none of neonatal syphilis; and for three dermatologists who referred only five patients, including two cases of secondary syphilis. 81 patients (45 per cent.) had positive

TABLE I *Specialties from which* 179* *patients were referred to the Venereology Department*, 1969-71

Specialty	*No. of consultants*	*Patients*	
		No.	*Per cent.*
Gynaecology	10	26	14·5
Psychiatry	15	26	14·5
General surgery	14	26	14·5
General medicine	11	25	14·0
Casualty	1	13	7·3
Blood transfusion unit	1	10	5·6
Neurology	5	9	5·0
Geriatrics	4	9	5·0
Genito-urinary surgery	2	8	4·5
Paediatrics	2	7	3·9
Dermatology	3	5	2·8
Physical medicine	2	4	2·2
Family planning	2	4	2·2
Ophthalmology	2	2	1·1
Cardiology	2	3	1·7
Radiotherapy	1	2	1·1
Total 16	77	179	99·9

*29 inpatients; 150 outpatients

serological tests for syphilis, three of which were biologically false (Table II).

In 98 patients the serological tests were negative; they followed the usual run of V.D. clinic patients, but 28 of them were non-urogenital. If these are added to the 81 with positive serological tests, we have a total of 109 cases, showing that the venereologist's consultative potential is over 60 per cent. non-urogenital.

Those who seek a change of title from 'venereology' to 'genito-urinary medicine' are thinking in terms of the hum-drum routine of the clinic adequately undertaken by the less experienced and are evidently regarding syphilis as no problem. It is parochial to do so for, though there is little syphilis in Great Britain today, an estimated incidence of 75,000,000 cases throughout the world deserves our continued attention. To enlarge the scope of our work or just to change the name of our specialty would neither attract more recruits nor enhance the

TABLE II *Diagnoses in the* 179 *referred patients*

Diagnosis			*No. of cases*		
Syphilis	Clinical	(*i*) previously treated requiring further antisyphilitic treatment	6		
		(*ii*) previously treated requiring no antisyphilitic treatment	10	16	23
		(*iii*) untreated		7	
	Latent	(*i*) previously treated requiring further antisyphilitic treatment	15		
		(*ii*) previously treated requiring no antisyphilitic treatment	31	46	55
		(*iii*) untreated		9	
	Total				78
Non-syphilitic	Biological false positive reactors				3
			Genito-urinary	*Non-genito-urinary*	
	Gonorrhoea		17	—	
	Nothing abnormal discovered		—	14	
	Trichomonal vaginitis		11	—	
	Candidiasis		10	—	
	Condylomata acuminata		10	—	
	Non-gonococcal urethritis		7	—	
	Reiter's disease		6	—	
	Non-genital non-venereal disease		—	6	
	Ophthalmia neonatorum		—	5	
	Salpingitis		3	—	
	Balanitis simplex		3	—	
	Scabies		—	3	
	Epididymitis		2	—	
	Circumscribed plasma cell balanitis		1	—	
	Total		70	28	98
Grand total					179

consultant's status, for he would become the poor relation of the urological surgeon. There is no harm in retaining our romantic euphemisms, such as St. Thomas' Hospital's Lydia Department and the Middlesex Hospital's James Pringle House, or our mundane pseudonyms such as Birmingham's Ward 19 and Newcastle's Ward 34. And here it may be said that the stigma which patients attach to attending these clinics exists in their minds whatever the title. The modern venereal diseases clinic is one which dispels shame rather than creates it.

It is no less fearsome to be in a fire than in a furnace. It is no less drenching to be caught in a downpour than in a deluge. Were a change in nomenclature to be made, it would be only a matter of time before the new appellation acquired the old connotation attaching to 'venereal'; moreover the new connotation itself would embrace the entire purlieu of the venereologist, commonly known as the 'sexually transmissible' diseases. This term is synonymous with venereal but can be used for those conditions which are not necessarily transmitted illicitly. It is a matter of practical psychology to distinguish them thus, and it is as well for the totality of domestic serenity that the law statutorily recognizes but three traditional diseases as 'venereal'.

There is no branch of medicine or surgery with which the venereologist is not concerned, to say nothing of the paramedical and sociological organizations and those engaged in them, such as probation officers, moral welfare workers, adoption societies, and family planning clinics. There is no age nor walk of life exempt from the need of his services; no secrets more precious than those he keeps; he is too pre-occupied with his share of the quarter of a million patients who annually attend special clinics for physical and psychological reasons connected with sex, especially the profligate variety, to over-concern himself with unrelated non-venereal disorders of the kidney, bladder, or uterus. He is already trying to cope with the commonest infectious disease, apart from measles, recorded by the Registrar General, with the world's third commonest disease after the common cold and influenza, and with one of the only two bacterial infections on the increase in the world today.

Let us pursue our vocation using the most apt and lilting word in the English language with which to describe it and rather change our concept of its implications, if change we must. Should we not widen our concept of venereology to include all medical aspects of venerey? An individual's place in society and his relationship to others, especially the opposite sex, is a subject in dire need of recognition and understanding. Such a subject should be included in the curriculum of all adult-minded school children, to say nought of medical students. Meanwhile, the medical profession would do well to storm the few remaining bastions of bigotry encountered within its own walls, not a stone's throw from V.D. clinics or Special Treatment Centres. Call them what we will, their purpose is unalterable. We may yet ponder the possibility of brushing up our knowledge of family planning, contraception, sterilization, indications for termination, psycho-sexual disorders, including impotence and infertility, and even marriage guidance. Here's scope indeed for co-ordination and unification. Whether we conquer or control venereal diseases or not, let us see to it that Venery-ology' thrives these 50 years hence.

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